Overwork Among Residents in India: A Medical Resident's Perspective

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Abstract

This paper argues that medical residents who do most of the hard work in big hospitals and medical colleges are overworked. A hierarchical organizational structure, staffing patterns, and fear of failure in examinations leads to overwork among residents going unreported. This can lead to poor academic performance and research work. Gaps in communication have serious implications on patient health. Undesirable practices like LAMA (leave against medical advice) also result from overwork. Issues of pay and contracts including mandatory service need to be looked into carefully. National and international recommendations on work hours have consistently been ignored. The solutions suggested are simple and easy to implement.

Keywords: India, overwork, residents

Introduction

At a time when there is a call for a complete and radical overhaul of the healthcare system of the country,[1] scant attention is being paid toward the ground workers of the biggest medical colleges and hospitals. Due to our crumbling healthcare system, there is a tremendous load on the existing facilities including the manpower. High cost of treatment in private facilities leads to an abnormally high patient load in few performing government facilities. Also, for fear of mortalities and associated ill-reputation, patients in terminal stages of illnesses are often referred to the public facilities by private practitioners.[2]

The organizational culture among medical establishment is very hierarchical.[3] There are reports of widespread bullying going unreported.[4,5] Chronic shortage of physicians leads to extreme amounts of overwork.[6] However, the junior members of the medical team are not in a position to express their reservations or opinions to the senior consultants who make major patient admission- and treatment-related decisions. The authors have personally seen orders being relayed down from those in the highest ladder to their juniors. Ultimately, the task is completed by the junior-most resident or even the intern. The staffing pattern is also unique; while the senior doctors, nurses, and paramedical staff including the ward boys are permanent government employees, the medical resident is a temporary contract worker who has an annual contract subject to renewal every year. The majority of residents are academic residents who have a sword of Damocles hanging on their shoulder. This sword is the fear of displeasing anyone in the old scheme of things and thus almost guaranteeing their failure in examinations. The passing rates in DNB examinations are extremely low.

Also, there is an acute shortage of postgraduate medical seats in relation to undergraduate seats in the country. In developed countries like USA, the postgraduate seats are more than the undergraduate seats. For e.g., in 2010, residency match 16,070 US medical school aspirants vied for 22,809 first year residency positions.[7] This is not the case in India. Thus, the residents are not even in a position to leave the "precious" seat of the course if they are not in a position to carry out their duties responsibly. Often, admissions to the said courses are expensive and/or coupled with contracts and bonds with penalty clauses and fines in tens of lakhs of rupees which are impossible to pay back.[8,9] This unique situation leads to a very high level of stress among residents. There are very few studies documenting resident burnout in India.

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This high workload leads to poor performance and tendency to make mistakes which can be and are fatal in medical environment. There are countless cases of medical negligence being regularly reported and documented which can be traced to overwork. While often there is a lack of support from senior collogues and faculty, who justify excessive work as tradition of good training process. Interestingly, residents take the major burden, while senior faculty members get leisure of flourishing private practice overtly or covertly allowed in many states. It takes toll on both standard of training and teaching.

Medical professionals are supposed to be aware of the stresses and is expected that they take care of these issues. However, what is sad and surprising is that such a large cause of mental stress sometimes even leading to suicides is ever present and criminally ignored by the medical administrators.[10] A typical work week of an anesthesia resident includes three duties and three regular days of work. A regular day of work includes OT duty, ICU/CCU/NICU/PICU duty, teaching seminars, thesis work, and running OPD services. While a duty day means 24 straight hours of emergency/casualty posting and OT service and responding to CPR calls. This "duty" day then blends into the next "regular" work day without a break. It is hard to conceive a human being function at his optimum on that particular day and afterwards without any sleep whatsoever. And, this sleep-deprived duty roster continues to operate for a full 3 years, i.e., the duration of residency.

There is an inherent knowledge asymmetry in a doctor-patient relationship. A patient admitted in a hospital is under great of stress and uncertainty himself. He/she is usually in great pain and is also afraid of his life; the hospital is a strange and unwelcome place full of chaos and misery. Considerate behavior is the least which is expected from the medical staff around him. But, the overworked and harried medical resident is not in such a position. This rude behavior toward patients is also a contributing cause of regular cases of violence toward the doctors by the patient attendants' frequently reported in media. Some practical implications of overwork also include unethical practices like LAMA (Leave Against Medical Advice). To reduce work load, some residents "unofficially" at times instigate the patient to go somewhere else for treatment. The residents express doubt at the ability of consultants and cite examples of previous treatment failures and mortalities to scare away the patient who then leaves the hospital against official medical advice.

Motivation of the residents also takes a beating and they are not interested in trying out new and experimental treatments which extend the borders of medical science. Thus, academic activities which include novel treatments are put on a backburner in busy government hospitals in order to continually clear the patient load. Teaching and learning activities often take a backseat in view of work pressures. Thesis work often becomes a formality which has to be completed somehow in the limited time. This is among the reasons of failing standards of medical research in the country.

There has been a long-standing debate in the country for classifying the pay of medical residents as salaries instead of stipends. There is a great disparity among pay scales in different states of the country. Usually, the pay is irregular and minuscule in comparison to his engineering or management counterpart and his age.[6] And, added to that is the long duty hours and responsibility. Predictability, the motivation takes a backseat.

There are ethical and legal barriers which have been ignored in letting this practice continue. The International Labor Organization recommendations prohibit more than 48 hours of work each week since 1962.[11] Similarly, the EU rules allow for only a 48-hour work week for a resident.[12] This was followed by major changes in National Health Service (NHS), UK. Even the factories act in the country provisions for payment of overtime and holidays for work more than 48 hours a week.[13]

The solutions are relatively simple. There needs to be a recognition and awareness of the contribution of medical residents toward the cause of healthcare in the country. In view of our economy getting bigger, healthcare also needs a bigger contribution both in terms of the size of the pie but also as a percentage. Healthcare in the country is woefully underfunded and this state of affairs is unacceptable. A large scale addition in the number of postgraduate residency seats coupled with clearing of the bottlenecks in the medical education system is the need of the hour. The surplus of medical graduates and shortage of postgraduates with plenty of hospitals available for training is a managerial problem. Solutions like National Board of Examinations and Faculty of Family Medicine in the country need to be mainstreamed. There needs to be flexibility in duty rosters being prepared with the option of post duty offs. Undergraduates are losing on clinical skills due to extreme focus on postgraduate entrance examinations for which they start preparing from the first year itself. This leads to doctors who have not even conducted a single delivery in their whole career, if these doctors are unable to get a specialization (which is true for many), they would be ill prepared to manage the primary health centers alone. Contribution in clinical care by undergraduates will lead to them acquiring better training and easing on the residents' work burden.

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